Precision Orthopedics & Sports Medicine
Patient History & Screening Form for MRI

★★★★★★★★★★★★★★★★★★★★★
★ PLEASE BRING BACK WITH YOU ★
ON THE DATE OF YOUR MRI
★★★★★★★★★★★★★★★★★★★★★

Patient Name: _____ Sex: M F Date: ____ / ____ / ____

Medical Record #: _____ D.O.B.: ____ / ____ / ____ Age: _____ Wt: ____ Ht: ____

Body Part & Side for MRI: _____ IOSM Physician: _____

What is the problem? Explain your medical problem in detail. How long have you had this problem?

_____

_____

Have you had a previous exam related to this problem? ☐ YES ☐ NO

If **YES**, Explain: _____

Have you taken and medication/alcohol today to relax you for the MRI? ☐ YES ☐ NO

If **YES**, What?: _____

Have you or do you have any of the following? If you answer YES, please explain in the blanks provided.

☐ YES	☐ NO	**Pacemaker** / Heart Surgery / Heart Valve. _____
☐ YES	☐ NO	**Brain Aneurysm Clips** / Brain Surgery. _____
☐ YES	☐ NO	Shunts / Stents / Intravascular Coil. _____
☐ YES	☐ NO	Eye Surgery / Implants. _____
☐ YES	☐ NO	Injury to eye involving metal or metal shavings. _____
☐ YES	☐ NO	Penile Prosthesis. _____
☐ YES	☐ NO	Orthopedic Pins, Screws, Rods, Ect. _____
☐ YES	☐ NO	Neurostimulator / Biostimulator. _____
☐ YES	☐ NO	History of Cancer or Tumors. _____
☐ YES	☐ NO	Previous Neck or Back Surgery. _____
☐ YES	☐ NO	Ear Surgery / Cochlear Implants / Hearing Aids. _____
☐ YES	☐ NO	Vascular Access Port. _____
☐ YES	☐ NO	Diaphragm / IUD / Pessary. _____
☐ YES	☐ NO	Metal Mesh Implants / Wire Sutures / Wire Staples / Internal Electrodes. _____
☐ YES	☐ NO	Any Electrical, Mechanical, or Magnetic Implants. Type? _____
☐ YES	☐ NO	Implanted Drug Infusion Pump / Insulin Pump. _____
☐ YES	☐ NO	Implanted Cardiac Defibrillator. _____
☐ YES	☐ NO	Pacing Wires, Swann Ganz Catheter. _____
☐ YES	☐ NO	Are You Pregnant? Last Menstrual Period? _____
☐ YES	☐ NO	Tattoo's / Permanent Make-Up / Body Piercings. _____
☐ YES	☐ NO	Dentures, Partials, or Dental Implants. _____
☐ YES	☐ NO	Gunshot Wounds, Shrapnel, BB's. _____

List Previous Surgeries: _____

MRI CONTRAST HISTORY:

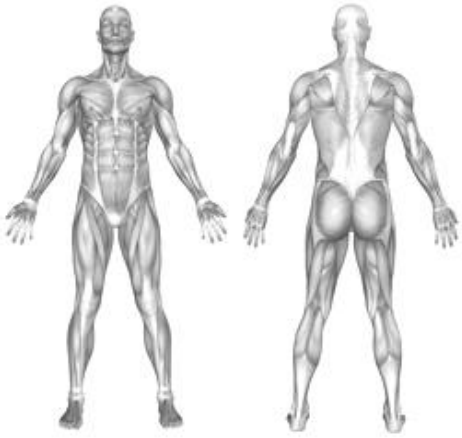
☐ **NOT APPLICABLE FOR THIS EXAM**

Any Personal History of:

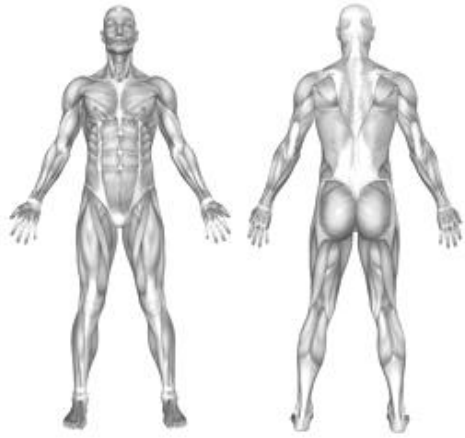
☐ YES	☐ NO	Seizures / Headaches / Dizziness	☐ YES	☐ NO	Stroke
☐ YES	☐ NO	Allergic Respiratory Disease	☐ YES	☐ NO	Kidney / Bladder Disease
☐ YES	☐ NO	Breast Feeding	☐ YES	☐ NO	Asthma
☐ YES	☐ NO	Blood Disorder / Sickle Cell Anemia	☐ YES	☐ NO	Liver Disorder
☐ YES	☐ NO	Are you breast feeding at this time?			
☐ YES	☐ NO	Reaction to **MRI CONTRAST** in the past? If **YES**, Explain: _____			

_____

Draw on the figures below where the pain or symptoms are located:



Please draw on the figure below the location of any metal in your (or the minor's) body:



Acknowledgement:
I have answered these questions to the best of my knowledge and understand the information presented to me.
I have also informed the technologist that I am not pregnant at this time.

_____ **Patient / Legal Guardian Signature**

_____ **Technologist / Witness Signature**

____ / ____ / ____ **Date**

* FOR CLINICAL USE ONLY *

Patient Discharge Instructions: ☐ YES ☐ NO

☐ **NOT APPLICABLE FOR THIS EXAM**

_____ **PROHANCE CC OF MAGNEVIST WITH A OMNISCAN** _____ **Ga & Type** @ _____ **Time** X _____ **# Of Punctures** BY _____ **Signature**

IN _____ **Lot #** _____ **Expiration Date:** _____ / _____ / _____

Physician Providing Contrast Coverage: _____

Contrast Reaction? ☐ YES ☐ NO **Explain:** _____

IF ADDITIONAL SPACE IS NEEDED FOR DOCUMENTATION USE PATIENT NOTES FORM

Discharged instructions for contrast reaction given? ☐ YES ☐ NO

INFORMED CONSENT FOR MRI, WITH OR WITHOUT CONTRAST INJECTION

Patient Name: _____ **Medical Record #:** _____

TO THE PATIENT: You have the right to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you. It is so that you may choose to give or withhold your consent to the procedure.

If you are pregnant or think that you may be pregnant, please inform the technician at once. It is very important that you Inform the technician if you have heart valves, a pacemaker, aneurysm clips or other implanted metallic or electrical devices.

Your physician has requested that we perform a **MAGNETIC RESONANCE IMAGING (MRI)** examination to obtain additional information. **MRI** uses a magnetic field and radio waves to produce an image of the internal body parts being examined. **MRI** is painless, and does not use x-rays or radiation. The only discomfort involved would be having to lie quietly in a confined space during the study. Because the **MRI** is a diagnostic procedure, it provides information that may aid your physician in diagnosing and treating your medical condition. Without the **MRI** scan, accurate diagnosis and proper treatment may be delayed.

As part of your **MRI**, a contrast agent may be injected into your vein in order to produce better images of the part of your body that is being examined. The **MRI** procedure may be conducted without the injection of the contrast agent, but the images may not be as helpful to the radiologist and your physician. If you wish to refuse the contrast injection, inform the technologist and the **MRI** will be conducted without the contrast agent.

POTENTIAL RISKS – THE FOLLOWING COMPLICATIONS ARE POSSIBLE: Anytime an injection is given, there is potential for pain, bleeding, bruising or swelling at the injection site. **MRI** exams requiring contrast may result in mild headache, nausea, and Itching or other vague symptoms for a short time after the injection. Additional allergic reactions in response to the contrast agent may include hives, shortness of breath or difficulty swallowing. There have been rare instances of death after the administration of the contrast agent. **IT IS VERY IMPORTANT THAT YOU INFORM THE TECHNOLOGIST IF YOU EXPERIENCE ANY OF THE CONDITIONS MENTIONED IN THIS FORM.**

NOTE TO PATIENTS: If you have previously had a **REACTION** to a contrast injection such as hives, severe itching, shortness of Breath and/or any significant reaction requiring hospitalization, a history of **ASTHMA** or other **ALLERGIC CONDITIONS**, any History of **SICKLE CELL ANEMIA** OR **KIDNEY DISORDER** are **PREGNANT OR BREAST-FEEDING**, you MUST inform the technologist. The safety of contrast for children under the age of 2 has not been established.

There may be other imaging alternatives, however your physician believes the **MRI** to be the best diagnostic test for you, considering your symptoms and condition. The benefit of this exam is to assist your physician with a diagnosis.

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I have been informed that there may be an additional charge as we do send our **MRI**'s to an outside radiology service. We cannot guarantee these radiologists will be contracted with your insurance plans.

I (WE) CERTIFY THIS FORM HAS BEEN FULLY EXPLAINED TO ME, THAT I (WE) HAVE READ IT OR HAVE HAD IT READ TO ME (US), THAT THE BLANK SPACES HAVE BEEN FILLED IN, AND THAT I (WE) UNDERSTAND ITS CONTENTS.

I (WE) HAVE BEEN GIVEN AN OPPORTUNITY TO ASK QUESTIONS ABOUT MY CONDITION, ALTERNATIVE FORMS OF ANETHESIA AND TREATMENT, THE PROCEDURES TO BE USED, AND THE RISKS AND HAZARDS INVOLVED, AND I (WE) HAVE SUFFICIENT INFORMATION TO GIVE THIS INFORMED CONSENT.

X_____ ____ / ____ / ____ _____

Patient / Legal Guardian Signature **Date** **Time**

X_____ ____ / ____ / ____ _____

Witness Signature **Date** **Time**